Vol. 13 January 2003

MaineCare UPDATE
Health Care for Maine People

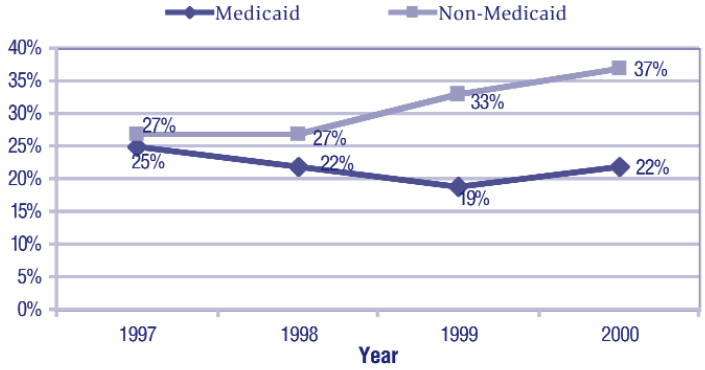
Lead Screening In Young Children

Maine law and federal mandates require all pediatric health care providers to screen one-and-two year olds enrolled in MaineCare programs for lead exposure with a blood lead screening test. The test for **one year olds** can be performed at any time **between 9 and 17 months,** and the test for **two year olds** can be taken **between 18 and 35 months,** giving the provider the flexibility to test children at a time when they are not being subjected to multiple additional procedures such as immunizations. Per Maine statute, analyses of blood lead samples on children less than 6 years of age can only be conducted at the state public health laboratory.

A survey conducted by the Barbara Bush Children's Center in 1999 suggested that most pediatric providers believe they screen all children in their practice for lead exposure. State screening results refute this belief with relatively low screening rates across the state. The disconnect appears to be in the manner in which the screening is achieved. When a medical provider hands the parent a lab slip and instructs them to take the child to the laboratory for the lead test, the provider believes that a lead screening has been done. However, many parents report that they do not follow through with obtaining the lead test for a variety of reasons, including lack of transportation and kids that are tired and cranky after a visit to the provider's office.

One option to ensure follow through with blood lead screening tests is to collect the sample while the child is still in the provider's office. A capillary or venous collection method can be used for blood lead specimens. The choice of

Blood Lead Screening Among Maine 1 Year Old Children Years 1997-2000



* Source Population–BMS, MBOH; Screening–HETL, MBOH

Lead *continued on page 2*

Buckle Up: Child Safety Seats

Current Maine law requires all children under 4 years of age to be restrained in a federally approved child safety seat. All other children under age 18 must be restrained in a safety belt. Children between the ages of 4-8 have come to be know as the "forgotten children" when it comes to child passenger safety.

Studies have shown that children between the ages of 4-8 and who are under 80 lbs. are at greater risk for injury when restrained with an adult seat belt. The belt systems in vehicles are designed for adults and do not fit properly on a small child. In a crash this can result in serious injury and, in some cases, death. The new law, which takes effect in January 1, 2003, provides additional guidance for parents, caregivers, transportation officials and law enforcement on several components in the law for transporting a child. The medical community can play an important role in spreading the word about child passenger safety.

In addition to requiring children under the age of 4 to be in a safety seat, as of January 1, 2003, the law will require children who are between the ages of 4-8 years and who weigh at least 40 lbs but less than 80 pounds to be secured in a federally approved child restraint system. These child restraint systems are commonly called "booster seats". For vehicles with lap only belts, restraint system called an *E Z Vest* is available.

A second change in the law requires a child who is less than 18

Buckle *continued on back*

Maine Department of Human Services
Kevin W. Concannon, Commissioner • Bureau of Medical Services • Quality Improvement Division
11 State House Station, Augusta, Maine 04333 • 800-566-3818 • TTY/TDD 800-423-4331
To receive this newsletter by mail, contact Health Care Management at 207-287-8820

Lead *continued from page 1*

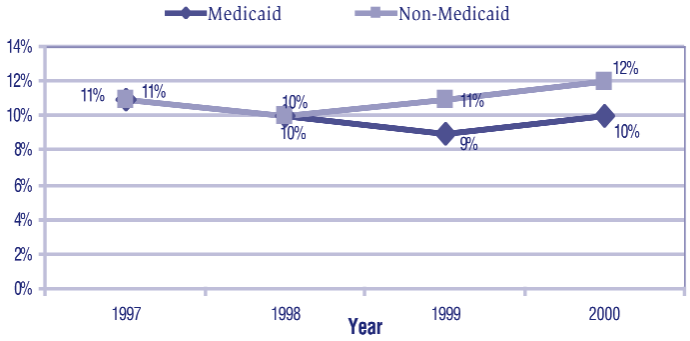
collection method may be determined by the expertise and capabilities of office personnel. Capillary blood lead collections are a quick and easy way to obtain blood lead samples in small children for whom venous blood collections may be difficult or more traumatic. The staff of the Maine Childhood Lead Poisoning Prevention Program offers on-site in-service training sessions for office staff in capillary blood lead collection techniques. Call the MCLPPP at **287-4311** for more information or to schedule a training in your office.

Some health care providers have questioned the accuracy of lead tests from capillary samples. Numerous studies have demonstrated the accuracy of capillary blood lead tests if adequate skin preparation is achieved. This entails vigorous washing of the child's hands and fingers prior to the collection. The most common mistake of phlebotomists and nurses collecting the sample is to simply wipe the finger with an alcohol wipe and collect the sample. Lead dust that is still present on the child's finger will then contaminate the blood sample. Careful attention to technique will eliminate this problem. Even with good technique, all elevated capillary blood lead results should be confirmed with a venous sample to ensure accuracy.

Providers that routinely perform capillary blood lead collections in their offices report that the entire procedure takes no more than **5 minutes**, with the actual blood draw taking 1-2 minutes. Laboratory requisitions can be completed and inserted in the chart the night before the office visit is scheduled. The sample can be mailed directly to the state public health laboratory or stored in a refrigerator for up to one week before mailing.

All equipment for blood lead collection, venous or capillary, can be obtained at no cost, from the state Health and Environmental Testing Laboratory by calling the blood lead section at 287-6649. The test kits include the microtainer tubes, lancets, alcohol wipes and 2 x 2 sponges. Mailing containers, lab requisition slips and supply order sheets are also included.

Blood Lead Screening Among Maine 2 Year Old Children Years 1997-2000



* Source Population–BMS, MBOH; Screening–HETL, MBOH

Providers will receive a written report of the test results in 1-2 weeks. If the test result is greater than 20 mcg/dl, the state laboratory will phone the results to the provider's office. All blood lead screening results are also sent to the Childhood Lead Poisoning Prevention Program (CLPPP) in the Bureau of Health. The program's nurse coordinator contacts all families of children with elevated blood lead levels, after confirming with the health care provider that the results were received and the provider's office has notified the parents of the elevated blood lead level. It is the expectation of the CLPPP that the primary care provider will notify the family of the diagnosis *prior to* the CLPPP contacting the family and initiating any interventions or support services. Full home inspections, or environmental investigations, are conducted when children are identified with a confirmed blood lead level of 20 mcg/dl or greater, along with a visit from a Public Health Nurse. By January 1, 2003, the MCLPPP expects to have a contract with a specialist in lead poisoning who will function as the clinical consultant for all Maine children with confirmed blood lead levels of 20+ mcg/dl.

Families whose children have blood lead levels that are 15 mcg/dl or greater are offered a home visit from a Public Health Nurse. Families whose children have elevated blood lead levels less than 15 mcg/dl receive a mailing of educational materials.

In 2001, over 400 children statewide were identified with blood lead levels of 10 mcg/dl or greater (MCLPPP data, 2001). 43 of these children had blood lead levels of 20 mcg/dl or more, with 6 of these children showing blood lead levels of more than 45 mcg/dl, prompting immediate treatment with chelation therapy. Screening rates for all children statewide have been improving over the past couple of years, however the screening rates for non-MaineCare enrolled children exceed the screening rates in the MaineCare enrolled population. The combined 1997-2000 screening rate for MaineCare enrolled children aged 12-23 months was 22%, compared to 31% of the comparable non-MaineCare population. Unfortunately, the MaineCare enrolled one-year-olds show a prevalence of elevated blood lead levels that is twice that of their non-MaineCare enrolled counterparts, or 10.6% versus 5.7% (MCLPPP data analysis, 2001).

Early identification and treatment, particularly environmental remediation efforts, can quickly reduce blood lead levels and prevent the serious long term effects associated with lead exposures, including developmental delays, behavioral problems such as

Lead *continued on back*

Voluntary Narcotic Prescriber Plan

Background of Benefit

In the fall of 2000, the Quality Improvement Division began receiving quarterly reports on member's narcotic utilization patterns Physician's Directed Drug Initiative (PDDI) reports. Through tracking and trending of these reports it was noted that over 1,000 members in any given quarter were obtaining narcotic prescriptions from 3-5 and/or 6 or more different prescribers. These prescriptions may have been filled at multiple pharmacies and may have included narcotic prescriptions obtained from multiple emergency room visits.

As a result, a project called "The Narcotic Prescriber Plan" was developed with a protocol for implementing the benefit.

Goals and Objectives of the Plan

There are two goals to this program.

1. Provide a safety net to MaineCare members who may be at risk for over-utilizing narcotics. This goal is accomplished in two ways;
   a. through the member's primary provider serving as the sole narcotic's prescriber when possible and approving additional prescribers as necessary and;
   b. managing pharmacy data to monitor utilization patterns and reduce potential problems with over-utilization.
1. Promote education and referral for pain management
   a. A registered nurse with experience in chronic pain management is available on a full time basis, Monday through Friday as a resource to members and providers.
   b. Assist members and providers in attaining chronic pain management services.

How do members respond to the program?

To date 452 members have voluntarily enrolled. In a recent survey of members that have been enrolled in the Plan for six or more months (N=153), 67% of members reported they found the program to be either helpful or very helpful while only 13% reported being dissatisfied with the program.

Does the program really work?

In an analysis between two groups eligible for the program using paired data from claims, 81% of enrolled members reduced narcotic utilization compared to only 27% of the non-enrolled group. There was an 18% reduction in emergency room services after joining the program. All statistics are significant at less than .05.

Providers/Prescribers can help through referral

The Narcotic Prescriber Plan recognizes the importance of primary providers as key to effective medication management. This is why MaineCare updates primary care providers on changes in utilization patterns of narcotics or medical services by their patients who are enrolled in the program. If you have patients that could benefit from this program and would like to learn more about how to refer or if you have any questions about this program, please call Joan Lancaster, RN. **Call her at 1-800-566-3818 ext. 7-4011, fax 287-1864 or email joan.lancaster@state.me.us.**

Blood Lead Screening Rates

MaineCare Lead Testing rates among FP/GPs and Pediatricians, 04/01/2001 - 3/31/2002.

Rank	Family Practice/GP	Age One	% with 1+ Test
1	Jennifer J. McConnell	10	90.0%
2	Joseph Nabozny	14	78.6%
3	Paul J. Davis	10	70.0%
4	A. Dorney	25	64.0%
5	Christopher T. Bartlett	16	62.5%
6	Sean T. Maloney	21	61.9%
7	Laurie C. Churchhill	13	61.5%
8	Eugene P. Paluso	25	60.0%
9	Mckim C. Peterson	10	60.0%
10	Kerry Crowley	26	57.7%

Rank	Family Practice/GP	Age Two	% with 1+ Test
1	A. Dorney	14	50.0%
2	John M. Van Summern	10	40.0%
3	Timothy Theobald	15	40.0%
4	James Stewart Smith	10	40.0%
5	D.L. Jeannotte	10	40.0%
6	Donald G. Brushett	46	34.8%
7	Kamlesh N. Bajpai	15	33.3%
8	Paul W. Templeton	18	27.8%
9	George K. Gardner, Jr.	19	26.3%
10	Laurie C. Churchhill	12	25.0%

Rank	Pediatrics	Age One	% with 1+ Test
1	Andrea L. Westinghouse	16	87.5%
2	Eileen Poulin	15	80.0%
3	Mary E. Connolly	14	78.6%
4	Renee R. Fournier	71	77.5%
5	Jorge Pineiro Vergne	65	76.9%
6	Richard P. Lambert	28	75.0%
7	John O. Vogt	12	75.0%
8	Faith Wilfley	19	73.7%
9	Maria S.J. Noval	15	73.3%
10	Rebecca Ayala	55	72.7%

Rank	Pediatrics	Age Two	% with 1+ Test
1	Kathleen Hickey	50	72.0%
2	Lila H. Monahan	61	68.9%
3	John Hickey	50	66.0%
4	Ann P. Simmons	43	65.1%
5	Iris Silverstein	41	63.4%
6	Donald R. Burgess	18	61.1%
7	Eileen Poulin	10	60.0%
8	Norman H. Seder	29	55.2%
9	Michael P. Hoffman	89	52.8%
10	Deborah L. Patten	19	52.6%
11	Kevin S. Flanigan	19	52.6%

Smoking Cessation Update

MaineCare wishes to remind providers that in September of 2002, reimbursement for tobacco cessation counseling was simplified and the fees were raised. Despite efforts to promote smoking cessation, tobacco use continues to be prevalent among MaineCare members. The cost of tobacco use, both in human suffering and dollars spent remains enormous in Maine.

The following CPT code can be used **ALONE** or **IN ADDITION** to other Evaluation & Management (E & M) or obstetrical codes. ***Documentation of the counseling being provided is required in the medical record***. This should include documentation of at least the following: an assessment of the member's willingness to quit or their progress in quitting, any ongoing barriers to quitting or staying tobacco-free, and a brief outline of whatever educational or motivational information was provided. Time spent will not be considered a factor. The E & M or obstetrical codes, whether used alone, or in conjunction with the preventative care code 99402 will continue to need adequate documentation as per the MaineCare Benefits Manual.

PLEASE NOTE: You may also bill this code for any MaineCare member under 21 years of age for counseling that child's parent-EVEN IF the parent is not covered by MaineCare. Again, appropriate documentation of counseling would need to be maintained in the child's healthcare record to substantiate the billing.

WITH ICD-9 DIAGNOSIS CODE 305.1 only (tobacco use disorder) after 09/01/02 .

CPT CODE MAINECARE FEE LIMITS 99402-use ALONE if the only service provided is tobacco cessation counseling or IN ADDITION to appropriate E & M or obstetrical code $20.00 3/patient/calendar year/doctor Codes that will be paid IN ADDITION to 99402 are:

99201-99205: NEW PATIENT OFFICE VISIT
99211-99215: ESTABLISHED PATIENT OFFICE VISIT
99381-99387: NEW PATIENT PREVENTATIVE CARE
99391-99397: ESTABLISHED PATIENT PREVENTATIVE CARE
99321-99350: DOMICILIARY, REST HOME, OR HOME SERVICES
99431-99436: NEWBORN CARE
59400-59622: ANTEPARTEM, DELIVERY, AND POST-PARTUM CARE

A guide is available which outlines current tobacco cessation counseling strategies.

Please call 1-800-321-5557(option #9) if you have billing questions or 1-866-796-2463 if you would like to request additional materials.

It is also important to note that MaineCare also provides coverage for almost all prescription and over the counter medications approved for the treatment of tobacco use.

In addition, the Bureau of Medical Services and the Bureau of Health are working in collaboration to provide smoking cessation support for MaineCare members who are interested in quitting. Behavioral counseling and follow-up can significantly reduce relapse rates.

The Maine Tobacco HelpLine is a tobacco counseling resource provided by the Bureau of Health and the Center for Tobacco Independence that provides individualized behavior counseling by trained health professionals at no cost to patients. Any Maine resident can call the HelpLine, 6 days per week at 800-207-1230. The HelpLine can be utilized to augment or follow-up services provided in your office.

Buckle *continued from page 1*

but older than 8 years and taller than 4' 7" to be properly secured in a safety belt.

In addition, as of January 1, 2003, the law also requires all children less than 12 years of age and weighing less than 100 pounds to be properly secured in the rear seat of the vehicle, if possible.

The Maine Injury Prevention Program in the Bureau of Health, in collaboration with the Bureau of Highway Safety provides public education and awareness to parents and other caregivers, health care providers, law enforcement and the public at large regarding occupant safety. These two agencies also support several programs that provide access to child safety seats for low-income families. Seats, along with educational materials and familiarization training on the proper installation of the seats, may be obtained from 41 child safety seat program sites throughout the state as well as through certified technicians and child safety seat fitting stations located throughout the state.

Please contact the Maine Injury Prevention Program at 287-9968 if you have further questions or for more information about child safety seats.

Lead *continued from page 2*

ADHD, and learning disabilities. Blood lead screening tests should also be considered in the differential diagnosis of children with abdominal cramping, anemia, and neuro-behavioral problems. It is also recommended that children with developmental disorders such as ADHD, autism or pervasive developmental disorder (PDD) who exhibit pica behaviors be tested at any age for lead exposures secondary to the pica.

For more information, contact:
MaryAnn Amrich, RN – Program Manager
Childhood Lead Poisoning Prevention Program
Maine DHS, Bureau of Health
Tel: 287-8753 Fax: 287-5355
maryann.amrich@state.me.us